Texas Department of Insurance, Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1609

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor's Name and Address:	MFDR Tracking #: M4-09-7824-01
BURDIN CHIROPRACTIC NEUROLOGY & REHAB GROUP. 9502 COMPUTER DR., STE. # 200 SAN ANTONIO, TX 78229	
Respondent Name and Box #: JUDSON ISD Rep Box # 16	

PART II: REQUESTOR'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Requestor's Position Summary: "According to Dr. Burdin, the treating doctor, he felt is was medically necessary to bring (claimant) in to discuss the ongoing problems within his case, as well as to discuss future plans for his recovery and treatment. By Division of Workers Comp. Rules, the Carrier is obligated to reimburse medical records provided for Designated Doctor Appointments. We received the first EOB on March 13, 2009 and payment for services were denied, stating the TWCC-73 was not properly filled out or completed. Dr. Burdin is not required to fill out Part II of the form if the patient is off work, which was the case for this patient. Our office rebilled the carrier and again denied for the same reason. We are required to fill out and fax a TWCC-73 to the patients employer for every office visit."

Principal Documentation:

1. DWC 60 package
2. Total amount sought - $120.00
3. CMS 1500
4. EOB's

PART III: RESPONDENT'S POSITION SUMMARY AND PRINCIPAL DOCUMENTATION

Respondent's Position Summary: None submitted.

PART IV: SUMMARY OF FINDINGS

Eligible Dates of Service (DOS)	CPT Codes and Calculations	Denial Codes	Part V Reference	Amount Ordered
1/19/09	99214	150	1, 2	$0.00
	99080-73	150	1, 3	$0.00
Total /Due:				$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code Section 413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division Rule 134.203, titled ***Medical Fee Guideline for Professional Services*** effective for professional medical services provided on or after March 1, 2008, set out the reimbursement guidelines.

1. These services were denied or reduced payment by the Respondent with reason code: "Submitted documentation does not support the level of service billed. 150-Payment adjusted because the payer deems the information submitted does not support this level of service. Original payment decision is being maintained. Upon review, it was determined that this claim was processed properly. Note not according to treatment guidelines, no change in status."

2. CPT code 99214 – "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other providers or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Physicians typically spend 25 minutes face-to-face with the patient and/or family."

   The Requestor billed CPT code 99214 for an office visit rendered on 1-19-09. A review of the submitted office visit report did not document two of the three key components for billing this level of office visit. Based upon the submitted report, the Requestor did not document a detailed examination or medical decision making of moderate complexity; therefore, reimbursement is not recommended.

3. CPT code 99080-73 – Work status report. Per Rule 129.5(d) "The doctor shall file the Work Status Report: 1) after the initial examination of the employee, regardless of the employee's work status; 2) when the employee experiences a change in work status or a substantial change in activity restrictions; and 3) on the schedule requested by the insurance carrier (carrier) its agent, or the employer requesting the report through its carrier, which shall not to exceed one report every two weeks and which shall be based upon the doctor's scheduled appointments with the employee."

   The Requestor noted in their position statement that the claimant remained off work.. The Requestor did not submit a copy of the DWC-73 report to support compliance with Rule 129.5(d). No reimbursement is recommended.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code Section. 413.011(a-d), Section. 413.031 and Section. 413.0311
28 Texas Administrative Code Section. 134.1 and 129.5
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Section 413.031, the Division has determined that the Requestor is not entitled to reimbursement for the services involved in this dispute.

ORDER:

Authorized Signature	Medical Fee Dispute Resolution Officer	August 3, 2009 Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division Rule 148.3(c).

Under Texas Labor Code Section 413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed $2,000. If the total amount sought exceeds $2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code Section 413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.